

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30459

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Lawn Primary Registration District No. 1002
 City St. P. (No. 3132 Central St) St. _____ Ward _____

File No. _____
 Registered No. 3506

2. FULL NAME

Mrs Agnes Frenney
 (a) Residence No. 3132 Central St. 5 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 45 yrs. mos. _____ ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thos Frenney

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13th 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 | 9 | 7

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at Home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Pa

10. NAME OF FATHER John Harrison

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Elizabeth Haley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

14. INFORMANT P. E. Frenney (Address) 3132 Central St

15. FILED 10/21, 1927 M. M. Crowe REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/20/27 1927

17. I HEREBY CERTIFY, That I attended deceased from 10/17/27, 1927, to 10-20, 1927 that I last saw him alive on 10-19, 1927, and that death occurred, on the date stated above, at H. A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic nephritis
131

CONTRIBUTORY (SECONDARY) 129a (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Albumen & casts of coma
 (Signed) A. J. Green, M. D.
10/21, 1927 (Address) 3506

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys Cem DATE OF BURIAL 10/27/27 1927

20. UNDERTAKER H. F. Mayberry & Co ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

A. J. Welch
835 Rachel's Bldg
Main 4929

Yes